ASO [redacted]

Benefit Program Application ("ASO BPA")

Application to Administrative Services Only (ASO) Group Accounts

Administered by Blue Cross and Blue Shield of Texas, a division of Health Care Services Corporation, A Mutual Legal Reserve Company, hereinafter referred to as the "Claim Administrator" or "HCSC"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 099218 Group Number(s): 099218 Section Number(s):

Effective Date: 10/01/2013 Anniversary Date (AD): 10/01/2013

Legal Employer Name: City of Laredo

(Specify the employer or the employee trust applying for coverage. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)

ACCOUNT INFORMATION

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer Identification Number: 746001573 SIC: 9199 Nature of Business: General Government N.E.C.

Primary Address: 1110 E. Houston St Public Entity? ☒ Yes ☐ No

City: Laredo State: Texas Zip: 78040-8019 Administrative Contact: Rosa Salinas

Title: H.R. Officer Phone Number: 956-791-7411 Fax Number: 956-791-7476 Email Address: rsalinas@ci.laredo.tx.us

Physical Address (if different from Primary - required): 1110 E. Houston St

City: Laredo State: Texas Zip: 78040-8019

Billing Address: P.O. Box 579

City: Laredo State: Texas Zip: 78042 Billing Contact: Jose F. Castillo

Title: Assistant Finance Director Phone Number: 956-791-7428 Fax Number: 956-791-7477 Email Address: jcastillo@ci.laredo.tx.us

Blue Access for Employers (BAE) Contact: Monica Flores

(The BAE Contact is the Employee of the account authorized by the Employer to access and maintain its account via BAE.)

Title: Acting H.R. Director Phone Number: 956-791-7474 Fax Number: 956-791-7476 Email Address: mflores@ci.laredo.tx.us

Subsidiary/Affiliated Companies: N/A Subsidiary/Affiliated Companies Address: N/A

Contact: N/A Title: N/A

City: N/A State: N/A Zip: N/A

Phone Number: N/A Fax Number: N/A Email Address: N/A

ERISA Plan: ☐ Yes ☐ No If yes, specify ERISA Plan Year: (mm/dd/yy)

ERISA Plan Administrator: Plan Administrator's Address:

PRODUCER OF RECORD INFORMATION

NO CHANGES SEE ADDITIONAL PROVISIONS

Effective: 10/01/2013

If applicable, the below-named producer(s)or agency(ies) is/are recognized as Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for Employer's employee benefit programs. This statement rescinds any and all previous POR appointments for Employer. The POR is authorized to perform membership transactions on behalf of Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.

1. *Producer(s) or Agency(ies) to whom commissions are to be paid: Roberto J Laurel

   Tax ID Number (TIN) of ☒ Producer or ☐ Agency: _____ Producer #: 000005269

   Producer Address: Street:4519 San Bernardo Ave Suite 202 City: Laredo Zip: 78041

   Phone: 956-724-9083 Fax: 956-726-1873 Email: bob@laurelassoc.com

Is Producer/Agency appointed with BCBSTX? ☒ Yes ☐ No

General Agent? ☐ Yes ☐ No

Affiliated with General Agent? ☐ Yes ☐ No

2. *Producer(s) or Agency(ies)** to whom commissions are to be paid:

Tax ID Number (TIN) of ☐ Producer or ☐ Agency: Producer #:

Agency Address: Street: City: _____ Zip: _____

Phone: Fax: Email:

Is Producer /Agency appointed with BCBSTX? ☐ Yes ☐ No

General Agent? ☐ Yes ☐ No

Affiliated with General Agent? ☐ Yes ☐ No

If commission split, designate percentage for each producer/ agency. **Note**: total commissions paid must equal 100%

Producer /Agency 1: _____%

Producer /Agency 2: _____%

3. Multiple Location Agency(ies): If servicing agency is not listed above as Item 1 or 2, specify location below:

* The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

** If commissions are split, please provide the information requested above on both producers/agencies. BOTH must be appointed to do business with BCBSTX.

SCHEDULE OF ELIGIBILITY

☒ NO CHANGES ☒ SEE ADDITIONAL PROVISIONS

1. Eligible Person means:
   - ☒ A full-time employee of the Employer.
   - ☐ A full-time employee who is a member of: _____ *(name of union)*
   - ☐ A part-time employee of the Employer.
   - ☒ A retiree of the Employer.
   - ☐ Other: _____

   Are any classes of employees to be excluded from coverage? ☐ Yes ☐ No

   If yes, please identify the classes and describe the exclusion: _____

2. Full-Time Employee means:
   - ☒ A person who is regularly scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the Employer.
   - ☐ Other: _____

3. Domestic Partners covered: ☐ Yes ☒ No

   If yes: A Domestic Partner, as defined in the Plan, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Covered Employees with Domestic Partners.

   If yes, are Domestic Partners eligible to continue coverage under COBRA? ☐ Yes ☐ No

   If yes, are dependents of Domestic Partners eligible for coverage? ☐ Yes ☐ No If yes, the Limiting Age for covered children of Domestic Partners means twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status or any combination of those factors.

4. Are children of any age who are medically certified as disabled and dependent on the employee for support and maintenance eligible for coverage? ☒ Yes ☐ No

   Are children over the Limiting Age who are medically certified as disabled and dependent on the employee for support and maintenance eligible for coverage under the plan if they were not covered under the plan prior to reaching the Limiting Age? ☐ Yes ☒ No

5. Are unmarried grandchildren eligible for coverage? ☒ Yes ☐ No

   If yes, must the grandchild be dependent on the employee for federal income tax purposes at the time application is made? ☒ Yes ☐ No

6. The effective date for a newly eligible person who becomes effective after the employer's initial enrollment date:
   - ☐ The date of employment.

☐ The _____ day of the month following the date of employment.
☐ The _____ day of the month following _____ days of employment.

☐ The _____ day of the month following _____ month(s) or _____ days of employment.
☒ The 91st day of employment.
☐ Other: _____

Is the waiting period requirement to be waived on initial group enrollment? (The waiting period means the waiting period an Employee must satisfy in order for coverage to become effective. Covered family members do not have to satisfy a waiting period to become effective.) ☒ Yes ☐ No

Are there multiple new hire employee waiting periods? ☐ Yes ☒ No

If yes, please attach eligibility and contribution details for each section.

7. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:
☒ The date such person ceases to meet the definition of Eligible Person.
☐ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
☐ Other: _____

8. The Limiting Age for covered children is **Twenty-six (26) years,** regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status or any combination of those factors. For plan years beginning before January 1, 2014, an ASO grandfathered group health plan may exclude an adult child under 26 from coverage only if the child is eligible to enroll in an eligible employer sponsored health plan (as defined in Section 5000A(f)(2) of the Internal Revenue Code) other than a group health plan of a parent.

To cover children age twenty-six (26) and over, you must select option i. or ii. below:

i. ☒ The Limiting Age for covered children age twenty-six (26) or over,
☐ who are unmarried
☒ regardless of marital status,
is _____ years. *Twenty-seven (27) through thirty (30) are the available options.*

ii. ☐ The Limiting Age for covered children **who are full-time students** and age twenty-six (26) or over,
☐ who are unmarried
☐ regardless of marital status,

is _____ years. *Twenty-seven (27) through thirty (30) are the available options.*

Student certification: ☐ Account or ☐ BCBSTX or ☐ None
Frequency of Certification Letters: Annually (AN) ☐ Quarterly (QU) ☐ Semi-Annually (SA) ☐
* Certification Schedule: Month 1: _____ Month 2: _____ Month 3_____Month 4:_____
* For Annual Notification, indicate one month (Jan-Dec) for notification, for Semi-annual, select 2 months, for quarterly, select 4 months

Automatically cancel dependents who reach the maximum limiting age? ☒ Yes ☐ No
However, such cancellation shall be postponed in accordance with any applicable federal or state law.

9. Termination of coverage upon reaching the Limiting Age:
☐ Coverage is terminated on the birthday.
☒ Coverage is terminated on the last day of the month in which the Limiting Age is reached.
☐ Coverage is terminated on the last day of the billing month.
☐ Coverage is terminated on the last day of the year (12/31) in which the Limiting Age is reached.
☐ Coverage is terminated on the group's Anniversary Date.

Will coverage for a child who is medically certified as disabled and dependent on the parent terminate upon reaching the Limiting Age even if the child continues to be both disabled and dependent on the parent? ☐ Yes ☒ No

However, such coverage shall be extended in accordance with any applicable federal or state law.

10. Enrollment:
Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a qualifying event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to termination of previous coverage, the first day of the Plan Month following receipt of the application. In the case of a qualifying event due to loss of coverage under Medicaid or

a state children's health insurance program, however, this enrollment opportunity is not available unless the Eligible Person requests enrollment within sixty (60) days after such coverage ends.

Late Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Open Enrollment Period. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period.

Late applicant enrollment options:

- ☒ Annual open enrollment – late applicant may apply during open enrollment and for applicants nineteen (19) years of age or older, be subject to a 12-month pre-existing waiting period (credit will always be applied).
- ☐ No Annual Open Enrollment – late applicants are never eligible for coverage (dental only).
- ☐ Annual open enrollment – no pre-existing waiting period.
- ☐ Late applicants may apply at any time – coverage is effective first of the month following receipt of the application. For applicants nineteen (19) years of age or older, an 18-month pre-existing waiting period applies.

Specify Open Enrollment Period: _____

11. Pre-existing waiting period:
    - ☐ Pre-existing waiting period waived for all participants up to age nineteen (19). All other participants age nineteen (19) and over must serve pre-existing waiting period. Benefits for treatment incurred during the _____ months prior to the effective date of membership will not be covered for _____ months after the effective date.
    - ☒ Pre-existing is waived on the account's initial enrollment. All other participants age nineteen (19) and over must serve pre-existing waiting period. Benefits for treatment incurred during the 6 months prior to the effective date of membership will not be covered for 12 months after the effective date.
    - ☐ Pre-existing waiting period waived for all participants.

12. Extension of benefits due to Temporary Layoff, Disability or Leave of Absence:
    Temporary Layoff: 0 days Disability: 0 days Leave of Absence: 0 days

    However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law.

13. COBRA Auto Cancel? ☒ Yes ☐ No

    Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.

CURRENT EMPLOYEE ELIGIBILITY INFORMATION

NO CHANGES Current number of Employees enrolled _____ SEE ADDITIONAL PROVISIONS

Total **number of Employees/Subscribers:**

1. on payroll 2412
2. on COBRA continuation coverage 1
3. with retiree coverage (if applicable) 348
4. who work part-time None
5. serving the new hire waiting period Unknown
6. declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) 1
7. declining coverage (not covered elsewhere) None

LINES OF BUSINESS
(Check all applicable products)

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

☐ Managed Health Care Coverage: ☒ **PPO**
- ☐ Dual Option
  - High Plan Name: _____
  - Low Plan Name:_____

☐ **EPO**
☐ **POS**
☐ **HMO**
- ☐ with Drug coverage
- ☐ without Drug coverage

☐ Consumer Driven Health Plan (BlueEdge)
- ☐ **HCA**, if selected, complete separate HCA Benefit Program Application
- ☐ **HSA,** if selected, provide HSA Administrator or trustee name:
- ☐ **FSA** (vendor: ConnectYourCare) *(available 1/1/2013)*

☐ Traditional coverage:
- ☐ Out-of-Area (Indemnity)
- ☐ Benefit Offering

☒ Prescription Drug Coverage:
- ☒ Prescription Drug Program
- ☒ Stand-Alone Prescription Drug Program

☐ Comprehensive Dental Coverage
- ☐ Plan _____ Choose an item
- ☐ Dual Option: Plan 1 _____ Choose an item
  Plan 2 _____ Choose an item

☐ Comprehensive Vision Coverage

☐ In-Hospital Indemnity (IHI)

☒ Wellness Incentives

☒ Stop Loss Coverage - If selected, complete separate Stop Loss exhibit

☐ Dearborn National Life Insurance - If selected, complete separate Life application

☒ HCSC COBRA Administrative Services - If selected, complete separate COBRA Administrative Services Addendum

COMMENTS: This group is renewing with no changes eff 10/1/2013

FINANCIAL DOCUMENT ADMINISTRATION
FEE SCHEDULE

Fee Schedule Period)

To begin on Effective Date of Coverage and continue for:

☒ 12 Months ☐ Other: Months

Administrative Charge (s)

☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS/ATTACHMENT

1. Type:
   - ☒ Medical
   - ☐ Medical / Dental
   - ☐ Other: _____

2. Administrative Charge Chart:

Product / Service	PPO	Rx Only		
Base Administrative Charge (Medical)	$46.96	$7.20	$	$
Choose an Item	$	$	$	$
Choose an Item	$	$	$	$
Choose an Item	$	$	$	$
*Prescription Drug Rebate Credit per Covered Employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit. Expected rebate amounts to be received by the Claim Administrator are passed back to the Employer with one hundred percent (100%) of the expected amount applied as a credit on the monthly billing statement on a per Covered Employee per month basis. Rebate credits are paid prospectively to the Employer and shall not continue after termination of the Prescription Drug Program. (Further information concerning this credit is included in the governing Administrative Services Agreement to which this ASO BPA is attached under the section titled "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS.")	$(9.91)	$(5.55)	$	$
Blue Care Connection® ("BCC") Program: Enhanced	$	$	$	$
BCC Program Buy Up(s): Description: Choose an Item	$	$	$	$
Description: Choose an Item	$	$	$	$
Other: _____	$	$	$	$
Other: _____	$	$	$	$
Other: _____	$	$	$	$
Other: _____	$	$	$	$
Other: _____	$	$	$	$
Total	$37.05	$1.65	$	$

Additional Comments:

Dental: NA	$	$	$	$

3. Termination Administrative Charge:

The Termination Administrative Charge applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category *(per Covered Employee per individual or family composite)* during the three (3) months immediately preceding the date of termination by the appropriate factors shown below.

Service	PPO	Rx Only		
Medical Run-off Administration Charge	$16.68	$16.68	$	$

Dental Run-off Administration Charge	$	$	$	$

Additional Comments:

4. BlueCard Program/Network access fee: $ (Available upon request)

5. **Not applicable to Grandfathered Plans**

External Review Coordination:

Employer acknowledges and agrees: (i) to a fee of $700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan; (ii) that the Claim Administrator's coordination shall include reviewing external review requests to ensure that they meet eligibility requirements, referring requests to accredited external independent review organizations, and reversing the Plan's determinations if so indicated by external independent review organizations; and (iii) that the external reviews shall be performed by an independent third party entity or organization and not the Claim Administrator. Amounts received by Claim Administrator and external independent review organizations may be revised from time to time and may be paid each time an external review is undertaken. Further, Employer elects for external reviews to be performed under the Federal Affordable Care Act external review process.

6. Reimbursement Provision: ☒ Yes ☐ No
If yes: It is understood and agreed that in the event the Claim Administrator makes a recovery on a third-party liability claim, the Claim Administrator will retain 25% of any recovered amounts other than amounts recovered as a result of or associated with any Workers' Compensation Law.

7. **Claim Administrator's Third Party Recovery Vendor:**
It is understood and agreed that in the event the Claim Administrator's Third Party Recovery Vendor makes a recovery on a claim, the Employer will pay no more than 25% of any recovered amount.

Plan Design Material

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

1. Benefit booklets – Is BCBSTX providing benefit booklets? ☒ Yes ☐ No
   - ☐ Standard benefit booklet (no additional charge)
   - ☒ Customized benefit booklets
     - ☒ No additional charge
     - ☐ Supplemental Billing**
   - ☒ Customized booklet covers*
     - ☒ No additional charge
     - ☐ Supplemental Billing**
   - ☐ ERISA plan information
     - ☐ No additional charge
     - ☐ Supplemental Billing**
2. Subscriber ID cards
   - ☐ Standard subscriber ID cards (no additional charge)
   - ☒ Customized ID card services
     - ☐ No additional charge
     - ☐ Supplemental Billing**
3. Network provider directories
   - ☒ No additional charge
   - ☐ Supplemental Billing**
4. Subscriber claim forms, enrollment forms, enrollment materials
   - ☒ No additional charge
   - ☐ Supplemental Billing**
5. Special mailings
   Provider directories to be mailed to home addresses: ☐ Yes ☒ No
   - ☐ Cost included in admin charge
   - ☐ Supplemental Billing**
6. Other: _____ Additional charge: $_____

* Custom booklet covers are not available on electronic documents.

**As indicated in fee table on previous page.

PAYMENT SPECIFICATIONS

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer Payment Method: ☐ Online Bill Pay ☒ Electronic ☐ Check

Employer Payment Period:
- ☒ Weekly (cannot be selected if Check is selected as payment method above)
- ☐ Twice-Monthly
- ☐ Monthly
- ☐ Other (please specify)

Claim Settlement Period: **Monthly**

Run-Off Period: Transfer Payments are to be made for twelve (12) months following the end of the Fee Schedule Period.

Final Settlement: Final Settlement to be made within (60) days after end of Run-Off Period.

BROKER/CONSULTANT COMPENSATION

The Employer acknowledges that if any broker/consultant acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's broker/consultant a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid the broker/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its broker/consultant.

OTHER PROVISIONS

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

1. Certificate of Creditable Coverage: ☒ Yes ☐ No

   If yes: The Employer directs the Claim Administrator to issue to individuals, whose coverage under the Plan terminates during the term of the Administrative Services Agreement to which this ASO BPA is attached, a Certificate of Creditable Coverage. The Certificate of Creditable Coverage shall be based upon information required for issuance of a Certificate of Creditable Coverage to be provided to the Claim Administrator by the Employer and coverage under the Plan during the term of the Administrative Services Agreement.

2. Summary of Benefits & Coverage:

   a. Claim Administrator will create Summary of Benefits & Coverage (SBC)?

      ☒ Yes. If yes, please answer question b. The SBC Addendum is attached.

      ☐ No. If No, then the Employer acknowledges and agrees that the Employer is responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will the Claim Administrator have any responsibility or obligation with respect to the SBC. The Claim Administrator is not obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer's contact information. A new clause (e) is added to Subsection C. in the Additional Provisions as follows: "(e) the SBC". (Skip question b.)

   b. Claim Administrator will distribute Summary of Benefits & Coverage (SBC) to participants and beneficiaries?

      ☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.

      ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to participants and beneficiaries as required by law, except that Claim Administrator will send the SBC in response to the occasional request received directly from individuals.

      ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is $1.30 per package. The distribution fee will not apply to SBCs that Claim Administrator sends in response to the occasional request received directly from individuals

3. The Massachusetts Health Care Reform Act requires employers to provide, or contract with another entity to provide, a written statement to individuals residing in Massachusetts who had "creditable coverage" at any time during the prior calendar year through the employer's group health plan and to file a separate electronic report to the Massachusetts Department of Revenue verifying information in the individual written statements.

   a. The Employer directs Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act. Such written statements and electronic reporting shall be based on information provided to the Claim Administrator by the Employer and coverage under the Plan during the term of the Administrative Services Agreement. The Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. The Employer acknowledges that the Claim Administrator is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. The Employer or its Covered Employees should seek advice from their legal or tax advisors as necessary.

      ☒ Yes ☐ No

   b. If no: The Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

4. Employer contribution. The percentage of premium to be paid by the employer is:

Health -- % or $						Dental -- % or $					
Emp:	%	$	**Dep:**	%	$	**Emp:**	%	$	**Dep:**	%	$

5. This ASO Benefit Program Application (ASO BPA) is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least 60 days advance written notice) of any changes that would cause any benefit package of its group health plan(s) (each hereafter a "plan") to not qualify as a "grandfathered health plan" under the Affordable Care Act and applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's grandfathered health plan status or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and part of the BPA and Agreement, and Employer represents and warrants that such Form is true, complete and accurate.

B. **Retiree Only Plans, Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans:** If the BPA includes any retiree only plans, excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's exempt plan status.

C. Employer shall indemnify and hold harmless Claim Administrator and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquires or actions, settlements or judgments brought or asserted against Claim Administrator in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any plan's design (including but not limited to any directions, actions and interpretations of the Employer), (d) any provision of inaccurate information, and/or (e) the SBC. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of administrative services.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of administrative services between the parties.

I UNDERSTAND AND AGREE THAT:

1. The proposed fees are effective for 12 months, subject to contract provisions, and are based on the information and conditions stated. Final fees are subject to review based on actual enrollment results. If there is a 10% or greater variance in the enrollment and/or less than the minimum enrollment requirement of NA, BCBSTX reserves the right to review the final fees. The information provided in this application is complete and accurate to the best of my knowledge. If this information is incomplete or inaccurate, BCBSTX may rerate the plan, withdraw the proposal or cancel the contract.
2. Has there been a significant change in the claims experience previously provided? ☐Yes ☐ No If significant changes have been made, complete and attach Account Experience (Addendum to BPA).
3. Have there been any significant changes in the previously provided location(s) of eligible employees? ☐ Yes ☐No If significant changes have been made, attach new census.
4. Receipt by BCBSTX of the advance administrative fee (where applicable), in the amount of $NA, and completed enrollment forms does not constitute approval and acceptance by the BCBSTX Home Office.
5. If applicable, effective NA, the above-named producer(s)or agency(ies) is/are recognized as Employer's Producer of Record (POR), to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for our employee benefit programs. This statement rescinds any and all previous Producer of Record appointments for this company. The above named agent(s) or agency(ies) is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by our company.
6. Producer Statement (if applicable): I certify that I have reviewed all enrollment materials. I have also advised the Employer that I have no authority to bind these coverages, to alter the terms of the Contract(s)/Policy(ies), this Benefit Program Application or enrollment material in any manner or to adjust any claims for benefits under the Contract(s)/Policy(ies).
7. BCBSTX will report the value of all remuneration by BCBSTX to ERISA plans with 100 or more participants for use in preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your Producer/consultant is eligible for the sale or renewal of self-funded and/or insured products.

Donald Coronado
Authorized BCBSTX Representative

Account Executive 7/1/13
Title Date

210-558-5119 / 210-558-5177
BCBSTX Telephone and Fax numbers

Robert J. Laurel
Producer Representative *(if applicable)*

fd9/30/13
Date

956-724-9083 / 956-726-1873
ProducerTelephone and Fax numbers

Signature of Authorized Purchaser

City Manager
Title

9/30/13
Date

* Execution of this document is based on a satisfactory resolution of BCBSTX claim overpayments as described in attached City of Laredo letter to BCBSTX dated September 30, 2013.